IC 27-8-16

Chapter 16. Medical Claims Review

IC 27-8-16-0.5

Applicability of chapter

Sec. 0.5. (a) This chapter applies to the following:

(1) A person who conducts medical claims review concerning health care services delivered to an enrollee in Indiana.

(2) A person who acts as a claim review consultant concerning the:

(A) appropriateness of; or

(B) amount charged for;

a health care service delivered to an enrollee in Indiana.

(b) This chapter does not apply to:

(1) the payment of benefits or compensation;

(2) the furnishing of medical, surgical, hospital, or nursing services; or

(3) the payment by an insurer or employer to the provider of health care services for services provided;

under IC 22.

As added by P.L.260-1995, SEC.1.

IC 27-8-16-1

"Claim review agent" defined

Sec. 1. (a) As used in this chapter, "claim review agent" means any entity performing medical claims review on behalf of an insurance company, a health maintenance organization, or another benefit program providing payment, reimbursement, or indemnification for health care costs to an enrollee.

(b) The term does not include the following:

(1) An insurance company authorized under IC 27-1-3 or IC 27-1-17 to do business in Indiana or the company's affiliated companies.

(2) An entity acting on behalf of the federal or state government. However, an agent described in this subdivision who performs medical claims review for a person other than the federal or state government is a claim review agent who is subject to the requirements of this chapter.

(3) A health maintenance organization or limited service health maintenance organization that holds a certificate of authority to operate under IC 27-13.

(4) An insurance administrator that is licensed under IC 27-1-25.

(5) An individual qualified and acting as an expert witness under the Indiana Rules of Trial Procedure.

As added by P.L.128-1992, SEC.2. Amended by P.L.26-1994, SEC.17; P.L.160-2003, SEC.25.

IC 27-8-16-1.5

"Claim review consultant" defined

Sec. 1.5. (a) As used in this chapter, "claim review consultant" means a person who:

(1) makes a recommendation or provides consultation to:

(A) an entity engaged in performing medical claims review; or

(B) an insurance company, a health maintenance organization, or another benefit program providing payment, reimbursement, or indemnification for health care costs to an enrollee;

concerning the appropriateness of a health care service or the amount charged for a health care service delivered to an enrollee in Indiana; and

(2) is not an employee of an entity referred to in subdivision (1)(A) or (1)(B).

(b) Making a recommendation or providing consultation concerning a health care service does not render a person a claim review consultant under this section if the recommendation or consultation concerns:

(1) coverage provided; or

(2) medical services rendered;

under IC 22.

(c) The term "claim review consultant" does not include the following:

(1) An insurance company authorized under IC 27 to do business in Indiana.

(2) An entity acting on behalf of the federal or state government. However, an agent described in this subdivision who performs medical claims review for a person other than the federal or state government is a claim review agent who is subject to the requirements of this chapter.

(3) A health maintenance organization or limited service health maintenance organization that holds a certificate of authority to operate under IC 27-13.

(4) An insurance administrator that is licensed under IC 27-1-25.

(5) An individual qualified and acting as an expert witness under the Indiana Rules of Trial Procedure.

(6) A person who engages in the prospective, concurrent, or retrospective utilization review of health care services.

(7) A person who engages in the identification of alternative, optional medical care that:

(A) requires the approval of the enrollee or covered individual; and

(B) does not affect coverage or benefits if rejected by the enrollee or covered individual.

(8) An individual who is a licensed health care provider who makes a recommendation or provides consultation concerning the appropriateness of health care service. However, this exception does not apply if the individual:

(A) makes any recommendations or provides consultation

concerning the amount charged for a health care service delivered in Indiana;

(B) makes any recommendations or provides consultation concerning the appropriateness of hospital services provided by a hospital licensed under IC 12-25 or IC 16-21;

(C) is employed by or under contract with an entity that is required to be registered under this chapter; or

(D) has received more than five thousand dollars ($5,000) in compensation during the present calendar year for providing consultation services concerning the appropriateness of health care services delivered to enrollees in Indiana.

(9) A claim review agent under section 1 of this chapter.

As added by P.L.260-1995, SEC.2. Amended by P.L.160-2003, SEC.26.

IC 27-8-16-2

"Department" defined

Sec. 2. As used in this chapter, "department" refers to the department of insurance.

As added by P.L.128-1992, SEC.2.

IC 27-8-16-3

"Enrollee" defined

Sec. 3. As used in this chapter, "enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy, a health maintenance organization contract, or another benefit program providing payment, reimbursement, or indemnification for the costs of health care for:

(1) the individual;

(2) eligible dependents of the individual; or

(3) both the individual and the individual's eligible dependents.

As added by P.L.128-1992, SEC.2.

IC 27-8-16-4

"Medical claims review" defined

Sec. 4. (a) As used in this chapter, "medical claims review" means the determination of the reimbursement to be provided under the terms of an insurance policy, a health maintenance organization contract, or another benefit program providing payment, reimbursement, or indemnification for health care costs based on the appropriateness of health care services or the amount charged for a health care service delivered to an enrollee.

(b) The term does not include the prospective, concurrent, or retrospective utilization review of health care services.

(c) The term does not include the identification of alternative, optional medical care that:

(1) requires the approval of the enrollee or covered individual; and

(2) does not affect coverage or benefits if rejected by the enrollee or covered individual.

As added by P.L.128-1992, SEC.2. Amended by P.L.135-1994, SEC.1.

IC 27-8-16-4.5
"Person" defined

Sec. 4.5. As used in this chapter, "person" means an individual, a corporation, a limited liability company, a partnership, or an unincorporated association.
As added by P.L.260-1995, SEC.3.

IC 27-8-16-5
Certificate of registration; issuance to agent

Sec. 5. (a) A claim review agent may not conduct medical claims review concerning health care services delivered to an enrollee in Indiana unless the claim review agent holds a certificate of registration issued by the department under this chapter.

(b) To obtain a certificate of registration under this chapter, a claim review agent must submit to the department an application containing the following:

(1) The name, address, telephone number, and normal business hours of the claim review agent.

(2) The name and telephone number of a person that the department may contact concerning the information in the application.

(3) Documentation necessary for the department to determine that the claim review agent is capable of satisfying the minimum requirements set forth in section 7 of this chapter.

(c) An application submitted under this section must be:

(1) signed and verified by the applicant; and

(2) accompanied by an application fee in the amount established under subsection (d).

(d) The department shall set the amount of the application fee required by subsection (c) and section 6(a) of this chapter in the rules adopted under section 14 of this chapter. The amount may not be more than is reasonably necessary to generate revenue sufficient to offset the costs incurred by the department in carrying out the department's responsibilities under this chapter.

(e) The department shall issue a certificate of registration to a claim review agent that satisfies the requirements of this section.
As added by P.L.128-1992, SEC.2. Amended by P.L.260-1995, SEC.4.

IC 27-8-16-5.2
Certificate of registration; application; requirements; application fee

Sec. 5.2. (a) A person may not act as a claim review consultant concerning health care services delivered to an enrollee in Indiana unless the person holds a certificate of registration issued by the department under this chapter.

(b) To obtain a certificate of registration under this chapter, a

person must submit to the department an application containing the following:

(1) The name, address, telephone number, and normal business hours of the person.

(2) The name and telephone number of a person that the department may contact concerning the information in the application.

(3) Documentation necessary for the department to determine that the person is capable of satisfying the minimum requirements set forth in this chapter.

(c) An application submitted under this section must be:

(1) signed and verified by the applicant; and

(2) accompanied by an application fee in the amount established under subsection (d).

(d) The department shall set the amount of the application fee required by subsection (c) and section 6(a) of this chapter in the rules adopted under section 14 of this chapter. The amount may not be more than is reasonably necessary to generate revenue sufficient to offset the costs incurred by the department in carrying out the department's responsibilities under this chapter.

(e) The department shall issue a certificate of registration to a claim review consultant that satisfies the requirements of this section.

As added by P.L.260-1995, SEC.5.

IC 27-8-16-6

Certificate of registration; renewal; transfer; notice of change in information

Sec. 6. (a) To remain in effect, a certificate of registration issued under this chapter must be renewed on June 30 of each year. To obtain the renewal of a certificate of registration, a claim review agent or a claim review consultant must submit an application to the commissioner. The application must be accompanied by a registration fee in the amount set under section 5(d) of this chapter.

(b) A certificate of registration issued under this chapter may not be transferred unless the department determines that the person to which the certificate of registration is to be transferred has satisfied the requirements of this chapter.

(c) If there is a material change in any of the information set forth in an application submitted under this chapter, the claim review agent or claim review consultant that submitted the application shall notify the department of the change in writing not more than thirty (30) days after the change.

As added by P.L.128-1992, SEC.2. Amended by P.L.260-1995, SEC.6.

IC 27-8-16-7

Minimum claim review agent requirements

Sec. 7. A claim review agent must satisfy the following minimum requirements:

(1) Provide toll free telephone access at least forty (40) hours each week during normal business hours.

(2) Maintain a telephone call recording system capable of accepting or recording incoming telephone calls or providing instructions during hours other than normal business hours.

(3) Respond to each telephone call left on the recording system maintained under subdivision (2) within two (2) business days after receiving the call.

(4) Protect the confidentiality of the medical records disclosed to the claim review agent.

(5) Include in every notification of a medical review determination based on the appropriateness of health care services delivered to an enrollee the principal reason for the determination.

(6) Ensure that every medical claims review determination based on the appropriateness of health care services delivered to an enrollee is:

(A) made by a provider; or

(B) determined in accordance with standards or guidelines approved by a provider;

who holds a license in the same discipline as the provider who rendered the service.

(7) Include in every notification of a medical review determination based on the appropriateness of the amount charged for a health care service delivered to an enrollee the following:

(A) An explanation of the factual basis for the determination.

(B) If the determination is based on any information from a claims data base, the name and address of the person or entity compiling the data base.

(C) If the determination is based on any information from a claims data base, a statement whether any of the information was obtained from a data base regarding amounts charged for health services performed outside Indiana.

(D) Any percentile limiter applied to determine the appropriateness of an amount charged for a health service provided to an enrollee.

(8) Ensure that every provider referred to in subdivision (6) who makes medical claims review determinations or approves standards or guidelines for medical claims review determinations for the claim review agent has a current license issued by a state licensing agency in the United States.

(9) Develop a medical claims review plan and file a summary of the plan with the department.

As added by P.L.128-1992, SEC.2. Amended by P.L.135-1994, SEC.2.

IC 27-8-16-8

Appeals procedure; written description; minimum standards;

notice of appeal procedure on limitation or reduction of benefits

Sec. 8. (a) An insurance company, a health maintenance organization, or another benefit program providing payment, reimbursement, or indemnification for health care costs that contracts with a claim review agent for medical claims review services shall maintain and make available upon request a written description of the appeals procedure by which an enrollee may seek a review of a determination by the claim review agent.

(b) The appeals procedure referred to in subsection (a) must meet the following requirements:

(1) On appeal, the determination must be made by a provider who holds a license in the same discipline as the provider who rendered the service.

(2) The adjudication of an appeal of a determination must be completed within thirty (30) days after:

(A) the appeal is filed; and

(B) all information necessary to complete the appeal is received.

(c) If a medical review determination results in a limitation or reduction of benefits, a notice of the appeals procedure shall be provided by the claim review agent to the provider who rendered the health care services.

As added by P.L.128-1992, SEC.2.

IC 27-8-16-9

Provider's statement; documentation of review agent capability

Sec. 9. To provide documentation demonstrating that a claim review agent is capable of satisfying the requirement of section 7(6) of this chapter, the claim review agent must provide a signed statement of a provider employed by the claim review agent verifying that determinations are:

(1) made by; or

(2) determined in accordance with standards or guidelines approved by;

a provider licensed in the same discipline as the provider who rendered the service.

As added by P.L.128-1992, SEC.2.

IC 27-8-16-9.5

Claim determinations based on data base information

Sec. 9.5. (a) As used in this section, "data base" means a data base that provides information concerning health care services or amounts charged for health care services.

(b) If a claim review agent bases a medical claims review determination concerning a health care service provided by a hospital licensed under IC 12-25 or IC 16-21 in whole or in part on information obtained from a data base, the information must relate exclusively to services provided by a hospital licensed under IC 12-25 or IC 16-21.

(c) If a claim review consultant makes a recommendation or

provides consultation concerning the appropriateness of or the amount charged for services provided by a hospital licensed under IC 12-25 or IC 16-21 based in whole or in part on information obtained from a data base, the information must relate exclusively to services provided by a hospital licensed under IC 12-25 or IC 16-21.

(d) This section does not apply to:

(1) medical claims review determinations made under subsection (b); or

(2) consultations or recommendations made under subsection (c);

regarding medical services provided under IC 22.

As added by P.L.260-1995, SEC.7.

IC 27-8-16-10

Fraudulent or misleading information; penalties

Sec. 10. A provider, an enrollee, or an agent of a provider or enrollee who provides fraudulent or misleading information to a claim review agent is subject to the appropriate administrative, civil, and criminal penalties.

As added by P.L.128-1992, SEC.2.

IC 27-8-16-11

Prohibited bases for compensation of claim review agents and consultants

Sec. 11. (a) The compensation of a claim review agent for the performance of medical claims review may not be based on the amount by which claims are reduced for payment.

(b) The compensation of a claim review consultant for making a recommendation or providing consultation concerning the appropriateness of or amount charged for a health care service delivered to an enrollee in Indiana may not be based on the amount by which a claim relating to the service is reduced for payment.

As added by P.L.128-1992, SEC.2. Amended by P.L.260-1995, SEC.8.

IC 27-8-16-12

Violations; claims review agent; notice; cease and desist orders; penalties; revocation or suspension of registration; review

Sec. 12. (a) If the department believes that a claim review agent or claim review consultant has violated this chapter, the department shall notify the claim review agent or claim review consultant of the alleged violation.

(b) The claim review agent or claim review consultant shall respond to a notice given under subsection (a) within thirty (30) days after receiving the notice.

(c) If the department:

(1) believes that a claim review agent or claim review consultant has violated this chapter; and

(2) is not satisfied, based on the response given by the claim review agent or claim review consultant under subsection (b),

that the violation has been corrected;

the department shall order the claim review agent or claim review consultant under IC 4-21.5-3-6 to cease all claims review activities in Indiana.

(d) If the department determines that a claim review agent or claim review consultant has violated this chapter, the department:

(1) shall order the claim review agent or claim review consultant to cease and desist from engaging in the violation; and

(2) may do either or both of the following:

(A) Order the claim review agent or claim review consultant to pay a civil penalty of not more than five thousand dollars ($5,000) if the claim review agent or claim review consultant has committed violations with a frequency that indicates a general business practice.

(B) Suspend or revoke the certificate of registration of the claim review agent or claim review consultant.

(e) An order issued or a ruling made by the department under this section is subject to review under IC 4-21.5.

As added by P.L.128-1992, SEC.2. Amended by P.L.260-1995, SEC.9.

IC 27-8-16-13

Confidential information

Sec. 13. (a) This chapter does not require a claim review agent or claim review consultant to disclose information that is proprietary.

(b) Any:

(1) information concerning standards, criteria, or medical protocols used by a claim review agent in conducting medical claims review; and

(2) other proprietary information concerning medical claims review conducted by a claim review agent;

that is disclosed to the department under this chapter is confidential for the purposes of IC 5-14-3-4(a)(1).

As added by P.L.128-1992, SEC.2. Amended by P.L.260-1995, SEC.10.

IC 27-8-16-14

Rules

Sec. 14. The department shall adopt rules under IC 4-22-2 necessary to carry out this chapter.

As added by P.L.128-1992, SEC.2.